STATE OF TENNESSEE
EMPLOYEE SICK LEAVE BANK
SECOND FLOOR, JAMES K. POLK BUILDING
505 DEADERICK STREET
NASHVILLE, TENNESSEE 37243-0635
TEL. (615) 741-5431 1-800-221-SEIL (7345)
FAX (615) 532-3209

FOR SLB USE ONLY

Dept:

Member: Hrs. Yr.

Hrs. Used: _____ Reassess: _____

Leave Expires: _____ Hrs: _____

7.5 ___ 8.0 ___ S ___ D ___

WITHDRAWAL REQUEST APPLICATION

Please complete and submit this Withdrawal Request Application through your Human Resources office. The Sick Leave Bank must receive this application no earlier than two weeks prior to the expiration of all accumulated sick, compensatory, and annual leave, but no later than thirty (30) workdays after the expiration of all accumulated leave.

Employee's Name: Last First Home Phone # ( )

Employee's ID Number: DOB:

Preferred E-mail Address for Receiving SLB Determinations:

Home Address: City State _____ Zip

Employee's Department and Position Title:

Have you previously received sick leave from the Sick Leave Bank? .....Yes ___ No ___

Name used during previous withdrawal if different from present name:

1) My absence is due to
   My first day absent due to this condition was
2) Did you enroll within the last 2 years? Yes ___ No ___ If yes, provide the names and telephone numbers of all the physicians from which you received treatment or advice for this illness/injury/medical condition:
3) Is your current illness/injury/medical condition work-related:
   A. From state employment?.....Yes ___ No ___
   B. From other employment or service connected? Yes ___ No ___ If yes, indicate employer/branch of service:
      Employer/Branch of Service Name: Date of Incident:
   C. Have you filed a Worker's Compensation claim with the Division of Claims or another employer? Yes ___ No ___
4) Have you applied for Social Security disability? Yes ___ No ___ Date applied
5) Are you currently approved for or receiving Social Security disability? Yes ___ No ___ If yes, effective date: _____
6) Have you applied for retirement through the Tennessee Consolidated Retirement System?.....Yes ___ No ___
7) Are you currently earning and/or receiving income from other employment? (excluding pensions) .....Yes ___ No ___

I provided my medical doctor/surgeon with a Medical Certification form to confirm my illness or injury as required by the Sick Leave Bank ("SLB") Guidelines. I instructed my medical doctor/surgeon to send the completed form directly to the SLB at the address listed at the top of the form. I understand that leave grants from the SLB shall not exceed more than thirty (30) consecutive days per application. I understand that the maximum number of days a member receives for an accident, illness, or an illness related to, resulting from, or recurring from a previously diagnosed illness is ninety (90) days. In addition, leave grants shall not exceed ninety (90) days within a twelve (12)-month period as defined in the guidelines.

I certify that the information given in this application is correct and complete to the best of my knowledge. I am aware that should investigation show any material misrepresentation of facts, I will not be considered for SLB benefits. The SLB Board of Trustees may remove me from the SLB, and I may be subject to disciplinary action up to and including dismissal. I hereby authorize the SLB to make all necessary investigations concerning this application. I further authorize and request any records or information, including but not limited to medical, Workers' Compensation, service connected disability, State Retirement or Social Security disability, that is sought in connection with this application be provided to the SLB.

Signature of Employee or Legal Representative and Date

Signature of Human Resources Officer and Date

Determination of initial applications made within ten (10) workdays from receipt of all necessary documentation.